STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155165	A. BUILDING 00 B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE	586 EASTERN BOULEVARD CLARKSVILLE, IN47129

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F0000	This visit was for Investigation of Complaint IN00090791. Complaint IN00090791 - Substantiated. Federal/state deficiencies related to the allegations are cited at F221, F323, and F9999. Survey dates: 5/23 and 5/24/11 Facility number: 000082 Provider number: 155165 AIM number: 100289640 Survey team: Jennie Bartelt, RN Census bed type: SNF/NF: 112 Total: 112 Census payor type: Medicare: 20 Medicaid: 91 Other: 1 Total: 112 Sample: 3	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 1, 2011 by Bev Faulkner, RN			
F0221 SS=D	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, record review, and interview, the facility failed to ensure resident assessment and care planning supported the use of the least and most effective restraint. The facility also failed to ensure care plans were followed related to release from the restraint during meal time. The deficient practice affected 2 of 2 residents reviewed related to restraints in a sample of 3. (Residents C and B) Findings include: 1. During the Initial Tour on 5/23/11 at 6:15 p.m., in the dining	F0221	F221 Physical RestraintsIt is the practice of this facility to ensure residents are free from any physical restraints imposed for the purpose of discipline or convenience and not required to treat residents medical symptoms.1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.Resident C and B careplans/C.N.A. assignment sheets were revised to include "Release seatbelt at Mealtimes" instead of "May release seatbelt at Mealtimes"(indicates this is optional). The nursing staff were in-serviced on the changes listed above.Resident C and B were re-assessed on 6/6/11 utilizing a "new" Pre-Restraint Assessment. Both residents will continue the use of their seatbelts. Residents	06/22/2011

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	room of the secured unit, Resident C was observed at the dining table seated in a wheel chair. During interview at this time, CNA #6 indicated the resident wore a seat belt. During interview at this time, LPN #7 indicated the resident had had multiple falls, and it was felt a seat belt was best for the resident. LPN #7 indicated the resident was doing well with the seat belt, which was considered a restraint for him. LPN #7 indicated the resident can get up and walk. On 5/23/11 at 6:55 p.m., Resident C's wheel chair was removed from behind the table, and LPN #7 asked if he wanted to walk. Using a gait belt, LPN #7 and CNA #8 assisted the resident to stand, and the resident was assisted to walk with bent knees and tiny shuffling steps, leaning slightly back, with the staff pulling up at the gait belt and holding under the resident's arms. Staff asked the resident if he was getting tired, and he was assisted to a dining room chair, and then		are reviewed every 30 days by the IDT for ongoing use of a physical restraint.On 5/16/11 the families of resident B and C were educated on the use of restraints and the risk involved. Both families were agreeable and voiced understanding of the risk involved.Therapy re-screened 6/6/11 resident C and B to determine if other interventions could be used. Therapy validated the use of the seat belt for both resident C and B and deemed the seatbelt as the least restrictive device.In-services were conducted with the Nursing staff on the Falls Prevention Program and Gait Belt Policy. The in-services included Post tests to ensure staff understanding. The In-services were conducted on 5/31/11 by the Staff Development Coordinator.2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.Two additional residents were identified with restrictive devices. The Inter Disciplinary Team(IDT) reviewed both residents careplans and C.N.A. assignment sheet and revised as indicated.The IDT team evaluates resident(s) for a restraint and prior interventions attempted when the decision has been made to utilize a restrictive device.3. What measures will be put into place or what systemic changes you will make to ensure	

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	transferred back to his wheel chair, and the seat belt was fastened. During observation on 5/24/11 at 1:15 p.m., Resident C was observed seated in a dining room chair at the table in the dining room of the secured unit. CNAs #10 and #12 were observed assisting Resident C to transfer the resident to his wheel chair, and the seat belt was fastened. During interview at this time, CNA #10 indicated the resident's wheel chair was a temporary one used to keep him safe. CNA #10 and CNA #12 were observed transferring Resident C to bed, and during interview at this time, both CNAs indicated the resident had declined greatly since his hospitalization. The clinical record for Resident C was reviewed on 5/24/11 at 2:05 p.m. The record indicated the resident was admitted to the facility on 4/8/10 with diagnoses including, but not limited to, dementia.		that the deficient practice does not recur.A new Pre-Restraint Assessments were completed on residents C, B and the other two residents which included use of prior interventions attempted. Revisions were made to the plan of care and C.N.A. Assignment Sheets as indicated.Nurses and Inter Disciplinary Team(IDT) were re-educated on 5/31/11.The IDT evaluates residents for a restraint and prior interventions attempted when the decision has been made to utilize a restricitve device.The DNS is responsible to monitor program for compliance.4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.The DNS will complete the Physical Restraint CQI tool for 4 weeks and monthly for 12 months. The CQI committee reviews the audits and if thresholds are not met action plans are developed to improve performance and determine need for further action. Non-complinace with facility procedures may result in re-education and/or disciplinary action.	

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	Nurse's Notes indicated the resident was discharged to a behavior unit on 3/29/11 and readmitted to the facility on 4/6/11. Fall Circumstance Reports indicated the resident fell as follows: 4/6/11 at 4:55 p.m., an unwitnessed fall in the bathroom doorway with the resident falling "going to bathroom;" 4/20/11 at 10:00 p.m., an unwitnessed fall in the resident's room during unassisted transfer; 4/23/11 at 2:45 p.m., an witnessed fall with no injuries in the dining room; and 5/14/11 at 2:00 p.m., an unwitnessed fall "was in bed after lunch - got up unassisted - had bed linen in hands - feet tangled in linen." A Physical Restraint Assessment, dated 5/16/11, indicated, "What are the medical symptoms/diagnosis that led to the use of a restraint? Unsteady gait/balance, impaired cognition r/t [related to] dementia. Current order for physical restraint:			

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	Res. to be [arrow pointing up] in W/C [symbol for with] front closure seatbelt r/t unsteady gait, balance, impaired cognition. Check every hour, release every 2 hours for ADLs [activities of daily living]. May release for meals, activities & with supervision....Check all applicable interventions used prior to initiation." Checked were: Medication review, Restorative measures, Toileting program, and Behavior management. Handwritten at Other was: Therapy involvement. Unchecked were: Lowering bed to floor, Concave mattress, Positioning side rails, Trapeze, Self-release belt, Direct supervision, Drop seat, Wedge cushion, Bed alarm, Chair alarm, and Sensor alarm. The assessment also indicated the "restrictive device assists the resident in reaching his/her highest level of physical and psychosocial functioning by: Decreasing his/her risk from injuries." A Physical Therapy Discharge			

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	Summary, dated 5/17/11, indicated, "Res DC [discharge] as he was not making any progress. Res. is in a WC [wheel chair] now due to multiple falls which are due to decline in cognitive and medical condition." During interview and request for therapy records on 5/24/11 at 4:00 p.m., the Occupational Therapist Rehab Manager indicated she could not locate information about use of the wheel chair for Resident C, except as indicated in the discharge summary. She indicated she remembered discussion about whether the resident would be safer in the chair or not. She indicated she remembered they did not want to use a seat belt for the resident, because they would be concerned about his safety. She indicated if the resident tried to stand while in the seat belt, that could cause tipping and cause him to fall. The Restraint Care Plan, dated 5/16/11, indicated Interventions			

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	including, but not limited to, "Restraint reduction plan is to remove restraint: During meal time." 2. During Initial Tour of the facility on 5/23/11 at 5:35 p.m., RN #3, Unit Manager, indicated Resident B had fallen previously and was at risk for falls. RN #3 indicated the resident's most recent fall resulted in a "brain bleed." RN #3 indicated the resident now wears a seat belt on her recliner. On 5/23/11 at 5:55 p.m., CNA #4 was observed pushing a resident down the hallway. The resident was reclined in a gerichair. The resident was observed to have a raised purplish area about the size of a golf ball to the left side of the forehead. The side of the face was yellowish from the forehead to the bottom of the cheek. RN #3 indicated the resident was Resident B. CNA #4 indicated she needed to put the resident to bed. When the resident's gerichair was rolled next to the bed, the resident was observed to be wearing a seat belt. The clinical record for Resident B was reviewed on 5/24/11 at 12:00 p.m. The record indicated the resident had resided at the facility since 2006. The resident's			

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	most recent admission to the facility was 4/23/10 following hospitalization for a fracture to the left hip and left shoulder after a fall from her gerichair. The resident's Plan of Care, with "Problem" dated 5/14/10, with the most current goal date of 3/16/11, indicated a problem of "Risk for fall with history of fall r/t [related to] impaired safety judgement (makes attempts to rise per self, weakness related to decline in general health. Recent fall occurrence." Interventions included, but were not limited to, getting the resident up to her gerichair "just before meals, to bed after meals," "place gerichair near nurses station for closer observation during periods of extreme restlessness," and chair alarms to the bed and gerichair. The resident's Care Plan, with a "Problem Start Date" of 3/8/11, with goal date of 8/24/11, indicated, "Resident is at risk for fall due to impaired mobility complicated by high risk medication." Approaches included, but were not limited to, "When up in gerichair place near nurses station for closer observation" and "Alarm to bed and chair." Handwritten next to the intervention for the alarm was: "5/3/11 D/C'ed [discontinued]." A physician's order, dated 5/3/11,			

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	indicated, "D/C PAC/PAB [personal alarm chair/personal alarm bed] - does not attempt to rise by self...." A Fall Circumstance Report, dated 5/13/11 at 7:45 p.m., indicated the resident had an unwitnessed fall when sitting in the recliner in the hallway by the resident's room. Interventions planned to prevent further falls indicated, "To sit at nurse's station or Rd [resident] placed immediately to bed [symbol for after] meals. A physician's order, dated 5/13/11 at 7:50 p.m., indicated, "Transfer Resident to [name of local hospital] for evaluation and treatment." Emergency Room notes, dated 5/13/11, indicated, "Impression: 1) Head contusion [symbol for with] intracranial hemorrhage....Admit observation." Nurse's Notes indicated the resident was readmitted to the facility on 5/17/11. A revised approach on the Care Plan related to fall prevention indicated, "5/17/11 [arrow pointing up]in recliner [symbol for with] front closure seat belt r/t impaired cognition, unsteady gait & balance, osteoporosis. Ck [check] q hr, release q 2 hr/ADLs may release at meals,			

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	activities & [symbol for with] supervision." Interdisciplinary Team Progress Notes, dated 5/16/11, indicated, "IDT [Interdisciplinary Team] [symbol for with] POA [power of attorney]. On 5/13/11 at 7:45 p.m., Rd noted on floor lying on left side in hallway....DNS [Director of Nursing Services] met [symbol for with] POA to discuss fall care plan & reviewed interventions for appropriateness. All are appropriate but feel Rd would benefit [word not legible] front closure seat belt r/t osteoporosis, DJD [degenerative joint disease] unsteady gait, balance, severely cognitive impairment & due to multiple falls. Discussed [symbol for with] MD and family present & all in agreement for seat belt. Explained risks of utilizing seatbelt & acknowledged understanding but still all in agreement for seat belt for safety. Rd not aware she is rising or placing self at risk for falls. New order will be on re-admit to have front closure seat belt." The Physical Restraint Assessment, dated 5/17/11, indicated: "What are the medical symptoms/diagnosis that led to the use of a restraint? Osteoporosis, DJD, CVA [stroke] unsteady gait & balance, dementia.			

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	Current order for physical restraint: front closure seatbelt when [arrow pointing up] in recliner r/t unsteady gait, balance, impaired cognition. Check every hour, release every 2 hrs/ADLs [activities of daily living]....Check all applicable interventions used prior to initiation." Checked were: restorative measures, lowering bed to floor, bed alarm, and chair alarm. (Bed and chair alarms had been discontinued 5/3/11, prior to the fall.) Unchecked were: Medication review, Concave mattress, Toileting program, Positioning side rails, Trapeze, Self-release belt, Direct supervision, Drop seat, Wedge cushion, and Sensor alarm. The assessment also indicated the "restrictive device assists the resident in reaching his/her highest level of physical and psychosocial functioning by: Decreasing his/her risk from injuries; Assists in proper body positioning/alignment." The facility's policy entitled "Physical Restraints" was provided			

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	on 5/24/11 at 3:00 p.m. by LPN #9. Review of the policy indicated, "...Restraint use will be considered only after less restrictive measures have failed....Procedure: ...6. ...Restraints cannot be used because of a family request in the absence of a medical symptom...." During interview on 5/24/11 during the Exit Conference completed at 5:00 p.m., the Administrator indicated Resident B's family was very involved in her care. The Administrator indicated the family insisted on use of some method to keep the resident in her chair after the fall on 5/13/11. This federal tag is related to Complaint IN00090791. 3.1-3(w) 3.1-26(o)			

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F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to provide supervision to ensure a resident at risk for falls did not fall from her chair for 1 of 3 residents reviewed related to falls in a sample of 3. (Resident B) Resident B sustained a brain contusion and soft tissue hematoma to the scalp. The facility also failed to ensure the resident was transferred safely using a gait belt as required by facility policy for 1 of 3 residents observed during transfer in a sample of 3. (Resident B) Findings include: During interview on Initial Tour of the facility which began on 5/23/11 at 5:35 p.m., RN #3, Unit Manager, indicated Resident B had fallen previously and was at risk for falls. RN #3 indicated the resident's most recent fall resulted in a	F0323	F323 Accidents and Supervision It is the practice of this provider to ensure the residents environment remains as free of accidents hazards as is possible.1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.Therapy re-screened on 6/6/11 resident B and C. Seat belt(s) were deemed appropriate and the least restrictive device for both resident B and C.IDT reviewed the Fall Care plan and C.N.A. assignment sheets were appropriate for resident B and C.Resident B and C were re-assessed on 6/6/11 utilizing a new Pre-Restraint Assessment and both residents will continue the use of their seatbelts. Resident are reviewed every 30 days by the IDT for ongoing use of a physical restraint.On 5/16 /11 and 5/17/11 the families of resident B and C were educated on the use of restraints and the	06/22/2011

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	"brain bleed." RN #3 indicated she was not present at the time of the fall, but her understanding was the aide was preparing to lay the resident down in bed, when the aide heard an emergency alarm sounding and went to answer the emergency alarm. RN #3 indicated she had not seen the resident try to get up on her own. RN #3 indicated the resident now wears a seat belt on her recliner. On 5/23/11 at 5:55 p.m., CNA #4 was observed pushing a resident down the hallway. The resident was reclined in a gerichair. The resident was observed to have a raised purplish area about the size of a golf ball to the left side of the forehead. The side of the face was yellowish from the forehead to the bottom of the cheek. RN #3 indicated the resident was Resident B. CNA #4 indicated to RN #3 she needed to put the resident to bed and requested the help of RN #3. The resident's gerichair was rolled next to the bed, and the resident was wearing a seat belt. The gerichair was placed in an upright position, and nurse and CNA grasped under the resident's arms and held the back of her pants on each side as the resident was transferred to bed. The resident bore minimal to no weight during the transfer. A gait belt was not used for the transfer. RN #3 left the room, and CNA #4		risks involved. Both families were agreeable and voiced understanding of the risk involved.An In-service was conducted on 5/31/11 with the nursing staff related to Falls Prevention Program and Gait Belt Policy. Both Inservices included post-tests to ensure staff understanding. The in-service wasconducted by the Staff Development Coordinator.2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.Residents with at- risk for falls have the potential to be affected by the alleged deficient practice.Staff have been re-educated on the Fall Prevention Program and the Gait Belt Policy by the Staff Development Coordinator on 5/31/11.Current residents will be re-assessed for fall risk. Those identified to be at-risk for falls will be reviewed by the IDT. Care plans and C.N.A assignment sheets will be reviewed and revised as appropriate.3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.Staff have been re-educated on the Fall Prevention Program and Gait Belt Policy by the Staff Development Coordinator on 5/31/11.Current residents will be re-assessed for fall risk. Those identified to be at-risk for falls will be reviewed	

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	provided personal care. During interview at this time, CNA #4 indicated she was on duty when Resident B fell and bumped her head. CNA #4 indicated the resident was in the hallway in her gerichair , and an emergency call light was going off. CNA #4 indicated Resident B was "laid back with eyes closed." CNA #4 indicated she went to answer the emergency call light. CNA #4 indicated she got the other resident in the bathroom cleaned up, and when she came out of the other resident's room, Resident B had fallen and had already been moved into her bed. CNA #4 indicated the nurse had "gone upstairs," and the other CNA had found the resident when she fell from her chair. CNA #4 indicated the fall did not knock Resident B out. CNA #4 indicated the resident's alarms (used to alert staff to a resident's rising unassisted) had been discontinued prior to the resident's fall. The clinical record for Resident B was reviewed on 5/24/11 at 12:00 p.m. The record indicated the resident had resided at the facility since 2006. The resident's most recent admission to the facility was 4/23/10 following hospitalization for a fracture to the left hip and left shoulder after a fall from her gerichair.		by the IDT. Careplans and C.N.A. sheets will be reviewed and revised as appropriate.Residents are assessed for fall risk upon admision/re-admission, and no less than quarterly or with a significant change. The charge nurse implements appropriate immediate interventions to prevent falls. The IDT team reviews falls in the morning clinical meeting Monday-Friday (excluding Holidays) to ensure appropriate interventions have been implemented. Those residents at-risk are reviewed by the IDT for the least restrictive device to prevent injury. The residents plan of care and C.N.A. assignment sheets are revised as needed.The DNS is responsible for monitor for program compliance.How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.The DNS will complete the Fall and Falls Prevention CQI tool weekly x 4weeks then every monthly for 12 months.Data collected will be submitted to the CQI Committee for review.CQI committee will review the data collected determine need for further action. If thresholds is not met an action plan will be developed to improve compliance.Non-compliance with facility procedures may result in re-education and/or disciplinary	

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	The resident's Plan of Care, with "Problem" dated 5/14/10, with the most current goal date of 3/16/11, indicated a problem of "Risk for fall with history of fall r/t [related to] impaired safety judgement (makes attempts to rise per self, weakness related to decline in general health. Recent fall occurrence." Interventions included, but were not limited to, getting the resident up to her gerichair "just before meals, to bed after meals," "place gerichair near nurses station for closer observation during periods of extreme restlessness," and chair alarms to the bed and gerichair. The resident's Care Plan, with a "Problem Start Date" of 3/8/11, with goal date of 8/24/11, indicated, "Resident is at risk for fall due to impaired mobility complicated by high risk medication." Approaches included, but were not limited to, "When up in gerichair place near nurses station for closer observation" and "Alarm to bed and chair." Handwritten next to the intervention for the alarm was: "5/3/11 D/C'ed [discontinued]." A physician's order, dated 5/3/11, indicated, "D/C PAC/PAB [personal alarm chair/personal alarm bed] - does not attempt to rise by self...." The resident's annual Minimum Data Set		action.	

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	(MDS) assessment, dated 2/25/11, indicated in the CAA (Care Assessment Analysis) section for falls: "...no HX [history] of recent or frequent fall. Current meds [medications] are not new or recently changed for her, and she has no noted side effects. She is assisted up daily to a recliner chair for comfort, and when restless has tendency to slide, and would be unable to prevent fall is slid too far...." No documentation in Nurse's Notes from 2/25/11 to 5/13/11 or Interdisciplinary Team notes from 2/25/11 to 5/13/11 indicated information related to the resident's tendency to slide from the gerichair or decision-making on the removal of the alarms from the resident's bed and gerichair. Two Fall Risk Assessments, dated 5/13/11, untimed, were in the record. One Fall Risk Assessment indicated, "Yes," and the other Fall Risk Assessment indicated, "No" to the question, "Resident is non-compliant or has history of non-compliance?" A Fall Circumstance Report, dated 5/13/11 at 7:45 p.m., indicated the resident had an unwitnessed fall when sitting in the recliner in the hallway by the resident's room. Interventions planned to			

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	prevent further falls indicated, "To sit at nurse's station or Rd [resident] placed immediately to bed [symbol for after] meals. A physician's order, dated 5/13/11 at 7:50 p.m., indicated, "Transfer Resident to [name of local hospital] for evaluation and treatment." Emergency Room notes, dated 5/13/11, indicated, "Impression: 1) Head contusion [symbol for with] intracranial hemorrhage....Admit observation." Results of Diagnostic Imaging, dated 5/15/11, indicated, "CT Head without Contrast...Impression: 1. Focal hyperdensity noted involving the right temporoparietal cortex most consistent with a brain contusion. Findings related to focal intracerebral hemorrhage may also be considered. There is mild adjacent edema. There is minimal localized mass effect in this region. These findings are likely related to head trauma with the presence of a countercoup injury given the presence of a scalp soft tissue hematoma seen involving the scalp soft tissues of the left frontal region. 2. A large scalp soft tissue hematoma is seen involving the soft tissues overlying the left frontal bone....."			

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	During interview on 5/23/11 at 8:05 p.m., LPN #11, Unit Manager for Hall F, indicated gait belts are to be used for all transfers. The facility's policy related to use of gait belts was provided 5/24/11 at 3:00 p.m. by LPN #9, Unit Manager for Hall C. Review of the record at this time indicated, "Gait belts are to be used at all times for transfers or mobility with the exception of recent surgical sites...." This federal tag is related to Complaint IN00090791. 3.1-45(a)(2)			
F9999	STATE FINDINGS 3.1-13 ADMINISTRATION AND MANAGEMENT The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of	F9999	F9990 State Finding Administration and ManagementIt is the policy of this facility to report unusual occurrences that directly affect the welfare, safety or health of the resident or residents, including but not limited to (D) major Accidents.1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.The E.D. was re-educated on the Indiana State Regulations related to	06/22/2011

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	the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (D) major accidents. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure a significant injury sustained by a resident who fell was reported to the Indiana State Department of Health. The deficient practice affected 1 of 3 residents reviewed related to falls in a sample of 3. (Resident B) Findings include: The clinical record for Resident B was reviewed on 5/24/11 at 12:00 p.m. The record indicated the resident had resided at the facility since 2006. A Fall Circumstance Report, dated 5/13/11 at 7:45 p.m., indicated the resident had an unwitnessed fall when sitting in the recliner in the hallway by the resident's room.		reporting (D) Major accidents on 6/10/11 by the Director of Operations. 2. How will you identify other residents having the portential to be affected by the same deficient practice and what corrective action will be taken.Residents who suffer from a accident have the potenital to be affected by this alleged deficient practice. Major accidents will be reported per State and Federal Guidelines. Each unusual occurence will be reported to the ASC Nurse Specialist to ensure proper reporting occurred. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice doesn not recur.The E.D. will consult with the ASC DNS Specialist, and/or Director of Operations unusual occurrences to ensure timely reporting. Unusual occurrences will be reported to the appropriate agency within 24 hours.The E.D was re-educated on ASC policy regarding Unusual Occurrence for Residents and Visitors. 4. How the Corrective Action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.The E.D. will complete the Abuse Prohibition and Investigation CQI tool weekly x 4 weeks and monthly x 9 months and report findings to the ASC Nurse Specialist and the CQI	

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	A physician's order, dated 5/13/11 at 7:50 p.m., indicated, "Transfer Resident to [name of local hospital] for evaluation and treatment." Emergency Room notes, dated 5/13/11, indicated, "Impression: 1) Head contusion [symbol for with] intracranial hemorrhage. 2) dementia. Admit observation." Results of Diagnostic Imaging, dated 5/15/11, indicated, "CT Head without Contrast...Impression: 1. Focal hyperdensity noted involving the right temporoparietal cortex most consistent with a brain contusion. Findings related to focal intracerebral hemorrhage may also be considered. There is mild adjacent edema. There is minimal localized mass effect in this region. These findings are likely related to head trauma with the presence of a countercoup injury given the presence of a scalp soft tissue hematoma seen involving the scalp soft tissues of the left frontal region. 2. A large scalp soft tissue hematoma is seen involving the soft tissues overlying the left frontal bone....." During interview completed on 5/24/11 at 12:40 p.m., the Administrator indicated the facility did not report this incident to		Committee. The ASC Nurse Specialist will conduct the Abuse Prohibition and Investigation CQI tool monthly to ensure proper reporting procedures were followed. CQI committee will review data and determine need for further action/review.	

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	the Indiana State Department of Health. This state finding is related to Complaint IN00090791. 3.1-13(g)(1)(D)			